
State:	District of Columbia	Filing Company:	United Teacher Associates Insurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	Life Individual Combined		
Project Name/Number:	Life Individual Combined/A6121515DC - Info.		

Filing at a Glance

Company:	United Teacher Associates Insurance Company
Product Name:	Life Individual Combined
State:	District of Columbia
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	09/01/2015
SERFF Tr Num:	GRAX-G130227678
SERFF Status:	Closed-APPROVED
State Tr Num:	
State Status:	
Co Tr Num:	A6121515DC - INFO.

Implementation	
Date Requested:	
Author(s):	SPI GreatAmericanFinancialRes
Reviewer(s):	John Rielley (primary)
Disposition Date:	09/02/2015
Disposition Status:	APPROVED
Implementation Date:	09/02/2015

State:	District of Columbia	Filing Company:	United Teacher Associates Insurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	Life Individual Combined		
Project Name/Number:	Life Individual Combined/A6121515DC - Info.		

General Information

Project Name: Life Individual Combined	Status of Filing in Domicile: Pending
Project Number: A6121515DC - Info.	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 09/02/2015
	State Status Changed:
Deemer Date:	Created By: SPI GreatAmericanFinancialRes
Submitted By: SPI GreatAmericanFinancialRes	Corresponding Filing Tracking Number:

Filing Description:

Please accept this letter as notification to your department of United Teacher Associates Insurance Company's intent to update the above referenced form, which was approved by your department on 02/06/2015, under file number GRAX-G129906186, by moving the company names of Continental General Insurance Company and United Teacher Associates Insurance Company from the Member Life Insurance and Annuity Companies section, to the Administration for Life Insurance and Annuities section. We certify there have been no language changes made to the form itself.

Please note that this informational filing is being submitted for; Manhattan National Life Insurance Company, Great American Life Insurance Company, Continental General Insurance Company, Central Reserve Life Insurance Company, Provident American Life and Health Insurance Company, and Loyal American Life Insurance Company, simultaneously under separate cover.

Company and Contact

Filing Contact Information

Will Walker, Compliance Filing Trainee	
P. O. Box 5420	513-723-2735 [Phone] 12735 [Ext]
Cincinnati, OH 45201-5420	513-412-1470 [FAX]

Filing Company Information

United Teacher Associates Insurance Company	CoCode: 63479	State of Domicile: Texas
PO Box 5420	Group Code: 84	Company Type:
Cincinnati, OH 45201	Group Name: Great American Financial Resources, Inc.	State ID Number:
(800) 854-3649 ext. [Phone]	FEIN Number: 58-0869673	

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	

SERFF Tracking #:	GRAX-G130227678	State Tracking #:		Company Tracking #:	A6121515DC - INFO.
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Product Name:	Life Individual Combined				
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
APPROVED	John Rielley	09/02/2015	09/02/2015

SERFF Tracking #:	GRAX-G130227678	State Tracking #:		Company Tracking #:	A6121515DC - INFO.
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Disposition

Disposition Date: 09/02/2015

Implementation Date: 09/02/2015

Status: APPROVED

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Policy Change Request, Part II	APPROVED	Yes

State:	District of Columbia	Filing Company:	United Teacher Associates Insurance Company
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Form Schedule

Lead Form Number: A6121515DC-1									
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	APPROVED 09/02/2015	Policy Change Request, Part II	A6121515D C-1	AEF	Revised	Previous Filing Number:		53.500	A6121515DC - 1.PDF
						Replaced Form Number:	A6121515DC		

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



Member Life Insurance and Annuity Companies:

- ☐ Great American Life Insurance Company®
☐ Manhattan National Life Insurance Company®

Administration for Life Insurance and Annuities:

- ☐ Loyal American Life Insurance Company®
☐ Continental General Insurance Company
☐ United Teacher Associates Insurance Company
☐ Provident American Life and Health Insurance Company

Life Products: P.O. Box 5416, Cincinnati, OH 45201-5416

POLICY CHANGE REQUEST, Part II

Name of Insured _____ **Policy Number** _____

Name of Owner _____ **Telephone No. of Owner** _____

Address of Owner _____ **City** _____ **State** _____ **Zip** _____

☐ Reinsure Policy Face Amount Increase \$ _____ Child(ren) \$ _____

Add Riders: ☐ Children's Term Life Insurance Rider

(Please Print – Complete Form in Full)

Full Name of Insured:	State of Birth	Date of Birth	Age	Sex	Build			Present Life Ins.
					Ft.	In.	Lb.*	
								\$

*If your weight has changed by over 10 lbs., in the last year, indicate amount and reason.

Address:	City:	State:	Zip:
Driver's License No.:	State Issued:	Social Security No.:	
Name of Employer:	Address of Employer:		
Occupation: (Describe and give active duties)			
Do you contemplate changing your occupation?			

Please print full name of all persons proposed for coverage. Show spouse's maiden name in parentheses, if applicable.

Spouse/Other:	State of Birth	Date of Birth	Age	Sex	Build			Present Life Ins.
					Ft.	In.	Lb.*	
								\$

*If weight has changed by over 10 lbs., in the last year, indicate amount and reason.

Address:	City:	State:	Zip:
Driver's License No.:	State Issued:	Social Security No.:	
Name of Employer:	Address of Employer:		
Occupation: (Describe and give active duties)			
Do you contemplate changing your occupation?			

Child 1:	State of Birth	Date of Birth	Age	Sex	Build			Present Life Ins.
					Ft.	In.	Lb.*	
								\$
Child 2:								\$

*If your weight has changed by over 10 lbs., in the last year, indicate amount and reason.

Have you in the past 2 years engaged in, or within the next 2 years do you intend to engage in aviation activities or hazardous sports avocation or hobbies? ☐ Yes ☐ No (If yes, please explain.)

NONMEDICAL DECLARATIONS (continued)					
<p>2. Has anyone proposed for coverage:</p> <p>a. Had a physical checkup, consultation, or surgery within the last five years?</p> <p>b. Been a patient in a hospital, clinic, or other medical facility within the last five years?</p> <p>c. Had an electrocardiogram, X-ray, or other diagnostic test within the last five years?</p> <p>d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?</p> <p>e. Been diagnosed or treated by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) or tested positive for antibodies to Human Immunodeficiency Virus (HIV)?</p> <p>3. Is anyone proposed for coverage now pregnant? If yes, expected due date: _____</p> <p>4. Is anyone proposed for coverage now under medical observation or treatment or currently taking any medication other than as stated above?</p> <p>5. Is anyone proposed for coverage currently taking medication? If "yes," list name, dosage, reason and date last taken. _____</p>	<p>Yes</p>		<p>No</p>		
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
Details of questions answered "Yes"					
Name of Person and Question No.	Disease or Injury	No. of attacks, duration	Dates	Results	Name, Address of Physician

I/we have read the above questions and answers, and hereby declare that the answers and statements as written on this Request are complete and true to the best of my/our knowledge and may be relied on by the Company. I/we agree that this Policy Change Request may form a part of any policy issued. I/we further agree that no policy, addition, or change applied for shall in any event become effective unless and until this Policy Change Request is approved at the Administrative Office of the Company and the full premium due is paid during the lifetime of all proposed insureds, as stated in this Request.

Signed _____	Date _____	Signed _____	Date _____
Owner		Spouse	
Signed _____	Date _____	Signed _____	Date _____
Insured		Additional Insured	
(Parent or guardian if Insured is under 18)			
Witness _____	Approved by _____		Date _____

AUTHORIZATION TO OBTAIN INFORMATION

I/we, the Proposed Insured(s), authorize any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, the MIB, Inc., consumer reporting agency, employer, or pharmacy benefit manager, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children, and any other nonmedical information of me or my minor children, to give to Great American Life Insurance Company/Manhattan National Life Insurance Company/Continental General Insurance Company/United Teacher Associates Insurance Company/Loyal American Life Insurance Company/Provident American Life and Health Insurance Company or its legal representative or its reinsurers any and all such information. I/we also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me or my minor children. The types of information may include my/our: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; (9) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV); (10) drug and alcohol treatment; (11) other personal information; (12) Motor Vehicle record, and (13) pharmaceutical information. I/we also authorize Great American Life Insurance Company/Manhattan National Life Insurance Company/Continental General Insurance Company/United Teacher Associates Insurance Company/Loyal American Life Insurance Company/Provident American Life and Health Insurance Company or their reinsurers, to make a brief report of my protected health information to MIB, Inc.

I/we understand the information obtained by use of the Authorization will be used by Great American Life Insurance Company/Manhattan National Life Insurance Company/Continental General Insurance Company/United Teacher Associates Insurance Company/Loyal American Life Insurance Company/Provident American Life and Health Insurance Company and its reinsurers to determine eligibility or continued eligibility for insurance and eligibility for benefits under an existing policy or a policy applied for. The insurance agent, producer or broker may also use the information to help update my/our insurance program. Any information obtained will not be released by Great American Life Insurance Company/Manhattan National Life Insurance Company/Continental General Insurance Company/United Teacher Associates Insurance Company/Loyal American Life Insurance Company/Provident American Life and Health Insurance Company to any person or organization EXCEPT to reinsuring companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my/our application, claim, or as may be otherwise lawfully allowed or required or as I/we may further authorize.

I/we know I/we may request to receive a copy of this Authorization. I/we agree a photographic copy of this Authorization shall be as valid as the original. I/we agree this Authorization shall be valid for two and one-half years from the date shown below.

I ACKNOWLEDGE receipt of the Notice to Persons Applying for Insurance and Notice of Disclosure of Information/MIB, Inc. Disclosure and authorize preparation of an investigative consumer report.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Signature of Insured _____ Date _____
(Parent or guardian if Insured is under 18)

Signature of Spouse (If Applicable) _____ Date _____

Signature of Additional Insured (If Applicable) _____ Date _____